


December 31, 2012

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Request for Comments Regarding HHS Notice of Benefit and Payment Parameters for 2014

Dear Madam Secretary:

Thank you for the opportunity to submit comments on the proposed Notice of Benefit and Payment Parameters issued by the U.S. Department of Health and Human Services. The policies included in the proposed Notice will significantly affect our state's insurance market. We have comments on a number of different areas of the proposed Payment Notice as outlined below.

Risk Adjustment

We remain concerned about HHS' use of a concurrent risk adjustment methodology, which uses data from a given time period to inform payment transfers for the same time period. A prospective model, which uses data from one time period to inform payment transfers in a future time period, creates effective incentives for carriers to more efficiently manage patient care. We urge HHS to develop and adopt a prospective model in the future and to collect risk adjustment data in a manner that supports the use of a prospective model.

We appreciate and support the flexibility offered to states in developing and implementing state-based risk adjustment methodologies. We particularly support states having the ability to collect risk adjustment data in a different manner than HHS, provided an alternative data collection strategy meets defined security and privacy safeguards.

We have concerns on two of the seven criteria HHS proposes to use to evaluate a state-based risk adjustment methodology:

- The extent to which an alternate risk adjustment methodology "encourages favorable behavior among providers and health plans and discourages unfavorable behavior". We encourage HHS to be clearer about what is intended by "favorable" and "unfavorable".

- The extent to which an alternate risk adjustment methodology "is easy for stakeholders to understand and implement". We are concerned this may be an unrealistic standard to

meet given the inherent complexities of a risk adjustment model. We appreciate it is essential for carriers to understand the risk adjustment methodology in order to effectively provide data and otherwise participate in the implementation of a risk adjustment methodology. We suggest revising this criterion by substituting "carriers" for "stakeholders".

Given the distributed data collection approach HHS will use, it is essential HHS implement a rigorous data validation program to promote confidence and reduce opportunities for gaming. The proposed Notice outlines a two-step process for validating data. HHS proposed three potential methods for establishing data validation standards for the initial data validation process. We believe HHS should use two of the potential data validation strategies together, including both HHS or an HHS-designated entity prospectively certifying auditors and HHS developing standards that issuers and initial validation auditors would follow. We believe the latter of these two strategies may be utilized in combination with certification of auditors, rather than as a substitute for the first strategy.

We also support HHS' proposal to adjust payments and charges for issuers that do not comply with the initial or second validation audit standards.

Reinsurance

We strongly oppose the proposed distribution of reinsurance contributions. We are concerned that this is a significant change in the approach to the transitional reinsurance program from the Premium Stabilization Rule published earlier this year. We had previously understood that assessments paid by Minnesota carriers would be distributed within Minnesota. The proposed Payment Notice significantly changes the distribution of reinsurance program dollars through the establishment of a national distribution mechanism. This will result in states with healthier populations subsidizing states with less healthy populations. Minnesota has invested in the health of our state population and we should not have to subsidize states that have not made similar investments. Minnesota carriers should not be required to subsidize carriers in other states.

Under the proposed regulation, there is a uniform per capita national contribution rate. This is inappropriate because health care costs vary widely between different states. The per capita rate should vary using some generally accepted index of health care costs by state. The contribution rate and the payment parameters can then be adjusted in each state so that the projected payments equal the anticipated contributions in that state.

The Minnesota Comprehensive Health Association (MCHA) is the state's high risk insurance pool. Minnesota had the first operational high risk pool in the country, having begun in 1976, and is the largest, with 26,000 members. We strongly recommend that high risk pools be allowed to participate in the transitional reinsurance program. If the high risk pools are unable to participate in transitional reinsurance program, they will be incented to move their members immediately to the commercial market to gain such coverage when a more orderly and phased in transition may be more desirable. Abrupt movement of the entire high risk pool population into the commercial market may be disruptive for the most sick enrollees as these very sick people

will be hesitant to make any changes to their health insurance coverage, especially if this transition causes changes to their medical care regimen. Minnesota's high risk pool has been considering an orderly, multi-year transition plan to minimize the cost and disruptive impact on enrollees and the market. We need flexibility relative to our high risk pool to effectively manage market transitions for this population.

In addition, if high risk pools are not allowed to participate in the transitional reinsurance program and they continue to exist for some period of time, carriers would pay both the federal reinsurance assessment as well as assessments for the MCHA program. An analysis by MCHA of their members whose annual claims exceed $60,000 suggests that Minnesota carriers would pay over $60,000,000 in 2014 to care for members of MCHA that could be paid for by the Federal Reinsurance Program.

Under the proposed regulation, the reinsurance program would be operated on a calendar year basis with an April 30th deadline to submit data to be considered for reinsurance payments from the previous calendar year. With this timeline, it seems possible to include runout for the calendar year claims through March 31. We advocate using runout so that claims that are incurred near the end of the year will be more fully represented, as the claims that are incurred earlier in the year.

Cost Sharing Reductions

We are concerned about an inconsistency in treatment of cost sharing between this proposed rule and that outlined in the proposed Essential Health Benefits (EHB) /Actuarial Value (AV) rule. The EHB rules define cost sharing as follows: "Any expenditure required by or on behalf of an enrollee with respect to EHB. The term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services." HHS clarified in the preamble to the EHB/AV rule that cost-sharing requirements for benefits from a provider outside of a plan's network do not count towards the annual limitation on cost sharing.

The Payment Notice, however, says that "cost sharing required of enrollees under any silver plan variation of a standard silver plan for an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing required in the standard silver plan or any other silver plan variation thereof with a lower AV".

We believe that varying treatment of whether a provider is in-network or out-of-network for purposes of cost-sharing will be a significant source of confusion to consumers, particularly because we anticipate a substantial amount of churn between various types of insurance affordability programs, including cost sharing reductions and premium tax credits. We recommend that cost sharing reductions apply only to EHB provided by in-network providers to remain consistent with other HHS rules that encourage consumers to use in-network providers.

Multi-State Employer Plans

We note that individually issued medical insurance policies are typically regulated by the state in which the policy was issued, regardless of the current residence of the insureds. However, group policies such as employer polices are typically regulated by the state in which the insureds work. We believe that self-insured employers or their contracted third-party administrators will easily be able to calculate either a percentage of premium or per-capita contribution separately for each state in which they have a work location. The risk adjustment program, which is designed to pool risk only within each state, should allocate individual policies by the state of issue, and group policies by the state in which the insureds work.

Similarly, section 153.360 of the proposed rule indicates that small employer coverage participates "in the applicable risk pool in the state in which the enrollee's policy was filed and approved." We recommend modifying this language for both the risk adjustment and reinsurance programs to the state in which the small employer has its main work location. We agree that one small employer should not be split among states, but it is not correct that an enrollee has a "policy." The employer has a policy, and each enrollee receives a "certificate of coverage" under the policy.

If HHS adopts our recommendation, it will need to clarify how collections from multi-state employers will be allocated by state. We suggest that allocation of collections be based on the employees' work locations.

We appreciate the opportunity to submit comments on the proposed Payment Notice. Thank you for your consideration.

Sincerely,

James W. Schowalter
Commissioner
Minnesota Management and Budget

Mike Rothman
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